In all patients α_1-antitrypsin serum levels were normal (median 1.6 g/l). High resolution CT-scan showed that the emphysema was paraseptal in distribution and hence quite distinct from the more uniformly distributed bullae of centrilobular emphysema, typical changes associated with a lifetime of tobacco smoking. However CMS had multiple and larger emphysematous bullae with pleural thickening (size 12 cm) than MS affected by small bilateral bullae (size from 0.5 to 7 cm). Spirometric tests of CMS confirmed reduced FVC and FEV1 value with a reduced FEV1/FVC ratio suggesting mild airways obstruction in contrast to normal values of MS. All patients were treated by VATS for prevention of relapsing pneumothorax. Bullectomy specimen of MS illustrated minor accumulation of pigmented histiocytes (smoker's macrophages) than of CMS where we found a coarser brown to black pigment [4]. The postoperative course of MS was unremarkable while CMS had prolonged air leaks and in one case was performed pleurectomy by thoracotomy. In contrast to Beshay who showed no difference among all patients of group I, we noted several differences for clinical, radiological and histopathological evaluation and in the postoperative course of CMS compared to MS. These observations suggest that cocaine, when smoked together with marijuana, might aggravate marijuana-induced lung injury. Is it coincidence? Fligiel and colleagues reported that the effects of cocaine and marijuana on the airway appear not to be additive [5]. However the authors report histopathologic features of mucosal biopsy but do not include alveolar lung tissue and bullous disease. Probably noxious components that are a mixture of cocaine smoke plus components included in marijuana smoke might stimulate an amplified inflammation response with a dramatic increase of injurious effects on the alveolar lung. Finally in the light of this hypothesis, further studies are required to assess the effects of marijuana when smoked by itself and in conjunction with other illicit substance on lung parenchyma.

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Reply to the Letter to the Editor

Reply to Fiorello et al.

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We thank Dr Fiorello [1] and his group for the additional information on the topic [2] and we assume we are not the only thoracic centre seeing this type of lung injury. It is true that we do not exactly know what these patients are smoking and additives as lead, talcum or other substances to increase weight when selling these drugs have been reported and it is of course difficult to identify the additives retrospectively in a specific patient.

We have to pay attention to this problem but also have to ask the question, as in a recent editorial in the European Respiratory Journal: 'Cannabis: the next villain on the lung cancer battlefield?' [3].

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Letter to the Editor

Surgery for isolated pleural recurrence from thymoma

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We read with great interest the article of Lucchi et al. [1] on surgical treatment of pleural recurrence of thymoma. As such recurrences are rare we want to add an additional case we recently encountered [2]. Recurrent myasthenia gravis was observed in a 43-year-old patient 3 years after radical thymectomy for which a partial pericardial resection had been necessary to obtain a complete resection. An isolated pleural recurrence was discovered above the left diaphragm which could be removed by video-assisted thoracic surgery